Tool for Transition from Perinatal Care to Primary Care: The "OB Checklist"

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Care of the HIV-positive pregnant woman can be complex. To assure that not only has each client received "routine" prenatal care but has also been given HIV-specific care, the Harris County Women's Program in Houston, Texas, has developed a flow sheet, the "OB checklist," that:

1) is used by physicians and nurse practitioners to follow each client's pregnancy, and

2) summarizes the prenatal course for the subsequent primary care provider.

It helps ensure that each woman 1) is counseled about partner notification and safer sex, 2) has had all of the recommended blood tests, 3) has initiated highly active antiretroviral therapy (HAART), 4) receives appropriate vaccinations, and 5) is connected with an HIV specialist primary care provider postpartum.

At the time of the six-week postpartum check-up, each client is given a copy of the OB checklist to take to her primary care doctor or nurse practitioner. The practitioner thus has a summary of the last 6 to 9 months of care.

Special Women OB Checklist **Name_____**

History _____ y/o G___ P___ ___ ___ LMP_____ EDC_____

□ Ryan White criteria: Date HIV+_____ Source_____

Abnormal Paps_____ H/O STDs_____ Condom Use_____

□ Meds prior to pregnancy_____

Partner: Aware of her status? □ Yes □ No HIV+? □ Yes □ No

Tested? □ Yes □ No In physician's care? □ Yes □ No

□ Prenatal vitamins given

□ Initial OB/HIV labs Date_____

Hct/MCV_____ WBC_____ Plts_____ Rubella I NI RPR_____

HbsAg_____ HbsAb_____ HbcAb_____ HAV_____ HCV_____

Hgb e'phoresis_____ Blood type A B AB O Rh pos neg RhAb pos neg

Toxo IgG_____ U/A_____ C&S_____ *UDS*_____ *What*_____ *Refer □*

Pap_____ GC_____ Chlamydia_____ Other_____

Initial/Follow-up labs

Date	_____	_____	_____	_____	_____	_____
VL	_____	_____	_____	_____	_____	_____
CD4	_____	_____	_____	_____	_____	_____
LFT	_____	_____	_____	_____	_____	_____
Bun/Cr	_____	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____	_____

□ PPD Negative Positive

□ 15-21 weeks: Triple screen Negative Positive (+ for NTD?Down?Trisomy 18)

1 hour BS (if + FH or h/o GDM or macrosomia) _____

□ Genetic counseling

□ 24-28 weeks: 1 hour BS_____ Hct/MCV_____ 3 hour GTT____/____/____/____

If indicated, □ RhAb Negative Positive □ Rhogam

□ Contraception plans_____ □ BTL consent Date_____

□ 34 weeks: Copy of prenatal records to patient

□ 35-37 weeks: GBS culture Negative Positive

□ Ultrasound

Date	**EGA**	**EDC**	**Other**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Vaccinations/Dates

Hepatitis A #1_____ #2_____

Hepatitis B #1_____ #2_____ #3_____

Pneumovax _____ Flu_____ Tetanus_____

Medications in pregnancy

_____ Confirmed start date_____

_____ Confirmed start date_____

□ Registry notified (1-800-258-4263) Date_____ ID#_____

□ City of Houston notified Date_____

Deliver @ □ BTGH □ St Lukes □ Other / HIV Meds □ continue □ discontinue

□ Copy of OB √list and PP visit note to PCP_____ □ TSC □ NW □ Other